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His last breath

Viridiana Saenz, BS[a], and Bernard Karnath, MD[b]

[a]School of Medicine, University of Texas Medical Branch, Galveston, Texas; [b]Department of Internal Medicine, University of Texas Medical Branch, Galveston, Texas

ABSTRACT

Dying alone in a hospital bed is not what I envision when I think about my own death. As a third-year medical student, I have the honor of serving as leader for No One Dies Alone at my medical institution. I want to share my story to inspire others to participate in vigils with one who is dying or to assist in the efforts to contact family.

KEYWORDS Compassionate companion; end of life; good death; healing presence

The definition of a good death includes that no one should die alone. This concept has remained nearly unchanged over the years.[1] Dying alone can carry a huge weight of loneliness, and loneliness in and of itself has been shown to be associated with increased levels of pain.[2] No One Dies Alone (NODA) addresses this need through volunteers committed to spending time with patients who are in the last 48 hours of life and without any visitors. The first NODA was funded in Oregon.[3] However, not allowing somebody to die alone is easier said than done.

I volunteered to work in the wards on a weekend. In a brief phone call with the upper-level resident, I received my patient assignments. One of them was a 64-year-old man who had a history of metastatic squamous cell carcinoma. The resident told me this man met the inpatient hospice criteria and requested NODA services for him. On chart review, this patient also had a history of stage 4 kidney disease secondary to his previous chemotherapy regimen, cisplatin. There was a nephrology note saying that dialysis was not going to change the overall prognosis. Palliative care documented a detailed discussion about hospice with the patient. Oncology was also involved in the care and had switched his chemotherapy regimen to a less nephrotoxic agent, pembrolizumab.

The morning of my service, I placed my student white-coat and stethoscope in the physician's room to sit on a vigil with this patient for a couple of hours prior to pre-rounds. The patient was able to squeeze my hand and nod in agreement when asked about his comfort. He was sleepy. I played relaxing music for him during my shift. Later, another volunteer arrived, so I left to start my rounds. By the time my team and I rounded on him, his breath had become agonal. After rounds, I inquired about his family or friends. The team told me that the patient allowed them to search on his cell phone for contacts. However, throughout days of hospitalization, they had been unsuccessful. From the most recent note from palliative care, his prognosis was hours. The patient was slowly becoming less able to interact and could no longer tolerate a conversation.

After finishing rounds and seeing the new patients in the emergency department, my attending dismissed me. I stayed to check my patient's cellphone and try to contact his family. His mobile was an older flip phone with a small keypad. To my surprise, there were no contacts in the registry. All messages seemed to be scams or advertisements. No social media or mail was set up. I was losing courage but thought of searching the call log as a last resort. There were unidentified calls with random numbers, so I dialed each number in the hope of reaching a close friend or family. After frantic efforts, his neighbor answered and reported they had a close friendship. The neighbor provided me the number of a cousin who subsequently shared with me the number of one of his brothers. The brother lived out of town but provided a phone number of the patient's niece who could come to the hospital sooner. I was surprised that no one knew that he was hospitalized.

It was the end of a long shift. We checked out to the night team. I worried this man was soon going to pass away

Corresponding author: Viridiana Saenz, BS, School of Medicine, University of Texas Medical Branch, 711 Holiday Dr., Galveston, TX 77550 (e-mail: Virii-21@hotmail.com)

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and decided to stop by his room for an evening vigil. I sat next to him and held his hand, determined to stay with him until his niece arrived. After sitting for about half an hour, his breaths were becoming more deep and less frequent and then he gasped for his deep last breath. Immediately, I notified his nurse and night doctor, who arrived to announce time of death. This man did not die alone, and it was an honor to be by his side. I left the room while the team was processing his death. When I arrived home, I logged onto the medical records where the death note reported that his niece had arrived to receive the news.

I could not help but replay this humbling experience in my head that night. A few minutes before he passed, I talked to him, hoping he could still listen. I told him about his family members who were notified. I told him he was much loved and that they cared for him very much. He teared up after I said those words. I want to believe his tear was a sign of comfort, joy, or peace. Shortly afterwards, his hand lost tone and his breathing stopped.

The meaning of these situations cannot be learned from studying for an exam but rather from experience. As a medical student, I had the time to be with my patient. I am aware that the opportunity to sit for vigils will lessen during residency due to higher patient load and level of responsibility. In the current clinical environment, time spent with patients is short. In busy hospital days, the floors reach full capacity with new admissions.

This experience changed me. I will always remember the importance of compassionate companionship when relatives are not present. Acts of caring for patients mean different things depending on the situation. This experience has become my motive to be intentionally benevolent when practicing medicine, especially with patients near the end of life.

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